Chapter 6.5

Billing on the UB-04 Claim Form

(UB-04 claim form has been revised effective 4/1/2007 to accommodate the NPI #)

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INTRODUCTION

Beginning April 1, 2007**,** the **UB-04** claim form can be used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04. The UB-92 version will no longer be accepted after this date. Beginning April 1, 2007 – May 22, 2007, AHCCCS will accept either UB-92 or UB-04 – EFFECTIVE 5/23/2007, AHCCCS WILL ACCEPT ONLY THE UB-04 VERSION.

- ☑ Revenue codes are used to bill line-item services provided in a facility.
- ☑ Revenue codes must be valid for the service provided.
- ☑ Revenue codes also must be valid for the bill type on the claim.
  - ✓ For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB-04 with a bill type 81X-82X (Special Facility Hospice).
  - ✓ If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.
- ☑ ICD-9 diagnosis codes are required.
  - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- ☑ ICD-9 procedure codes must be used to identify surgical procedures billed on the UB-04.

COMPLETING THE UB-04 CLAIM FORM

The following instructions explain how to complete the UB-04 claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

NOTE: This chapter applies to paper UB-04 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.azahcccs.gov. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

COMPLETING THE UB-04 CLAIM FORM CONT.

1.Billing Provider Data **Required**

Enter the billing provider name, address and telephone number.

1

Arizona Hospital
123 Main Street
Phoenix, AZ 85000

NOTES: The billing provider address MUST be a street address. P O Box or Lock Box addresses are to be entered in the Pay-To Address field of the form.

2. Pay-To Name and Address **Required if applicable**

The address that the provider submitting the bill intends payment to be sent **IF** different than that of the Billing Provider (see #1).

3a. Patient Control Number **Required if applicable**

This is a patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services (accounts receivable) containing the financial billing records and any postings of payments. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

3b. Medical/Health Record Number **Required if applicable**

This is the number assigned to the patient's medical/health record by the provider.

4. Type of Bill **Required**

This code indicates the specific type of bill. The first digit is a leading zero (do not include leading zero on electronic claims). Facility type (2nd digit), bill classification (3rd digit), and frequency (4th digit). See *UB-04 Manual* for codes.

2. PAY TO NAME AND ADDRESS	3a. PATIENT CONTROL NO.	4. TYPE OF BILL
	3b. MEDICAL/HEALTH RECORD NO.	111

COMPLETING THE UB-04 CLAIM FORM CONT.

5.Federal Tax Number **Required**

Enter the facility's federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
86-1234567			

6.Statement Covers Period **Required**

Enter the beginning and ending service dates of the period included on this bill.
NOTES: the "From" date should not be confused with the Admission Date (see #12).

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. Reserved
	02/15/07	02/20/07	

7. Reserved **Not required**

8 a - e. Patient Name/Identifier **Not Required**

Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer.

9. Patient Address **Required**

The mailing address of the patient.

10. Patient Birth Date **Required**

11. Patient Sex **Required**

COMPLETING THE UB-04 CLAIM FORM CONT.

12. Admission/Start of Care Date **Required**

The start date for this episode of care. For inpatient services, this is the date of admission. For other services, it is the date the episode of care began**.**

12 ADMISSION/START OF CARE	13 ADMISSION HOUR

13. Admission Hour **Required if applicable**

The code referring to the hour during which the patient was admitted for inpatient or outpatient care.

14. Priority (Type) of Visit (Inpatient only) **Required**

A code indicating the priority of this admission/visit. *See UB-04 Manual for codes.*

15. Source of Referral for Admission or Visit (Inpatient only) **Required**

A code indicating the source of the referral for this admission or visit. *See UB-04 Manual for codes.*

16. Discharge Hour (Inpatient only) **Required if applicable**

Code indicating discharge hour of the patient from *inpatient care.*

17. Patient Discharge Status (Inpatient only) **Required**

A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (as reported in FL6, Statement covers Period). *See UB-04 Manual for codes.*

18 - 28. Condition Codes **Required if applicable**

A code(s) used to identify conditions or events relating to this bill that may affect processing. *See UB-04 Manual for codes.*

29. Accident State **Required if applicable**

The accident state field contains the two-digit state abbreviation where the accident occurred. Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code. *See UB-04 Manual for codes.*

COMPLETING THE UB-04 CLAIM FORM CONT.

30. Reserved **Not Required**

Not currently used.

31 – 34. Occurrence Codes and Dates **Required if applicable**

The code and associated date defining a significant event relating to this bill that may affect payer processing. *See UB-04 Manual for codes.*

35 – 36. Occurrence Spans Codes and Dates **Required if applicable**

A code a related dates that identify an event that relates to the payment of the claim. *See UB-04 Manual for codes.*

37. Reserved **Not Required**

Not currently used.

38. Responsible Party Name and Address **Required if applicable**

The name and address of the party responsible for the bill.

39 – 41. Value Codes and Amounts **Required if applicable**

A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. *See UB-04 Manual for codes.*

42. Revenue Codes **Required**

Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. Revenue Code categories are four digits. *See UB-04 Manual for codes.*

43. Revenue Description **Required**

The standard abbreviated description of the related revenue code categories included on the bill. The description should correspond with the Revenue Codes as defined by the NUBC. *See UB-04 Manual for descriptions.*

44. HCPCS/Accommodation Rates **Required if applicable**

Enter the Healthcare Common Procedure Coding System (HCPCS) applicable to the ancillary service and outpatient bills. Enter the accommodation rate for inpatient bills. (when associated revenue code is 0100 – 0219).

COMPLETING THE UB-04 CLAIM FORM CONT.

45. Service Date (Outpatient) **Required if applicable**

The date (MMDDYY) the *outpatient* service was provided.

46. Service Units **Required**

A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, renal dialysis treatments, etc.

47. Total Charges **Required**

Total charges pertaining to the related revenue code for the current billing period is entered in the statement covers period. Total Charges includes both covered and non-covered charges. Note – the 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total on the final page 0 Use Rev Code 0001 for total charges.

48. Non-covered Charges **Required if applicable**

Reflect the non-covered charges for the payer as it pertains to the related revenue code. Note – the 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total on the final page 0 Use Rev Code 0001 for total charges.

49. Reserved **Not Required**

Currently not used.

50. Payer Name **Not Required**

Name of the payer that the provider might expect payment for the bill.

51. Health Plan Identification Number **Not Required**

This is a number used by the health plan to identify itself.

52. Release of Information Certification Indicator **Required**

Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.

53. Assignment of Benefits Certification Indicator **Required**

Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

54 a - c. Prior Payments – Payer **Required if applicable**

The amount the provider has received (to date) by the health plan toward payment of this bill.

A. Primary B. Secondary C. Tertiary

COMPLETING THE UB-04 CLAIM FORM CONT.

55. Estimated Amount Due - Payer **Not required**

The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

56. National Provider Identifier (NPI) – Billing Provider **Required**

The unique identification number assigned to the provider submitting the bill; NPI is the National Provider Identifier.

57 a. Other (Billing) Provider Identifier **Required if applicable**

A unique identification number assigned to the provider submitting the bill by the health plan. Enter AHCCCS # for atypical providers.

58. Insured's Name **Not Required**

The name of the individual under whose name the insurance benefit is carried.

59. Patient's Relationship to Insured **Not required**

Code indicating the relationship of the patient to the identified insured.

60. Insured's Unique Identifier (AHCCCS ID #) **Required**

The unique number assigned to the health plan to the insured. AHCCCS does not require.

61. Insured's Group Number **Not required**

The group or plan name through which the insurance is provided to the insured. AHCCCS does not require.

62. Insured's Group Number **Not required**

The identification number, control number, or code assigned by the carrier or administrator to identify the group number under which the individual is covered. AHCCCS does not require.

63. Treatment Authorization Code **Not required**

A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payor. You may include the AHCCCS Prior Authorization Number but AHCCCS does not require that you provide the number on the claim. If there is a Prior Authorization approved within the AHCCCS Claims system, the claim will validate the presence of the Authorization during processing.

COMPLETING THE UB-04 CLAIM FORM CONT.

64. Document Control Number (DCN) **Not required**
A control # assigned to the original bill.

65. Employer Name (of the Insured) **Not required**
The name of the employer that provides health care coverage for the insured individual. AHCCCS does not require.

66. Diagnosis and Procedure Code Qualifier (ICD) **Not required**
The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

67A - Q. Principal and Other Diagnosis Codes and P OA Indicator **Required**
Enter the principal and other ICD-9 diagnosis code. Behavioral Health providers must NOT use DSM-4 diagnosis codes. Present on Admission (POA) Indicator is also required by AHCCCS. The POA Indicator applies to the diagnosis codes for claims involving inpatient admissions. Refer to the UB-04 Manual for usage guidelines.

68. Reserved **Not required**
Not currently used.

69. Admitting Diagnosis **Required**
Required for **inpatient** bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.

70 A – C. Patient's Reason for Visit (Outpatient only) **Not required**
AHCCCS does not require this field to populated.

71. Prospective Payment System (PPS) Code **Not required**
AHCCCS does not require this filed to be populated.

72 A – C. External Cause of Injury (ECI) Code **Required if applicable**
The ICD-9 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

COMPLETING THE UB-04 CLAIM FORM CONT.

73. Reserved **Not Required**

Currently not used.

74 A - E. Principal and Other Procedure Codes and Dates **Required if applicable**

Required on INPATIENT claims when a procedure was performed. Not required on Outpatient claims. Enter the ICD-9 code that identifies the inpatient procedure performed at the claim level during the period covered by the bill and the corresponding date. Enter date as MMDDYY.

75. Reserved **Not Required**

Currently not used.

76. Attending Provider Name and Identifiers (NPI) **Required if applicable**

The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Required on INPATIENT claims and to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

77. Operating Physician Name and Identifiers (NPI) **Required if applicable**

The name and identification number of the individual with the primary responsibility for performing surgical procedures. Required if a surgical procedure code is listed on the claim.

78 – 79. Other Provider (Individual) Names and Identifiers **Not required**

The name and NPI number of the individual corresponding to the Provider Type category indicated in this section of the claim. *Refer to UB-04 for usage guidelines.*

80. Remarks Field **Required if applicable**

Area to capture additional information necessary to adjudicate the claim. Enter the Claims Reference Number (CRN) assigned to the original bill by AHCCCS. Required when a claim is a replacement or void to a previously adjudicated claim and the Bill Type (FL-04) indicates a void or replacement.

81. Code – Code Field **Required if applicable**

To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by NUBC. *Refer to UB-04 for usage guidelines.*